Peer Based Recovery Support Services Provider Billing Manual

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1. OVERVIEW

This billing manual is designed to be a reference document for consumers, family members, providers of primary care, behavioral healthcare, social services, and hospitals involved in delivering Peer Based Recovery Support Services (PBRSS). This manual has been developed by the Rhode Island Executive Office of Health and Human Services (EOHHS), including Medicaid and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to guide service implementation and billing. For more information on Medicaid billing and claims processing, visit the Provider tab on the EOHHS website at: www.eohhs.ri.gov/ProvidersPartners/BillingampClaims.aspx.

2. DEFINITIONS

Peer Recovery Specialist (PRS)– A behavioral healthcare professional credentialed by the Rhode Island Certification Board (RICB). Peer Recovery Specialists must meet the qualifications in the CMS State Medicaid Director Letter, #07-011, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf. Individuals must acknowledge a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and have received or are currently receiving treatment and/or community support for it. Or, individuals must acknowledge personal experience with a family member with a similar mental illness and/or substance use disorder.

Required Services – Interventions that promote socialization, long-term recovery, wellness, self-advocacy, and healthy living skills to Medicaid eligible individuals with a mental health and/or substance use disorder through education, coaching, navigating, and mentoring.

Eligible PRS– Certified PRS shall work under the direction of a licensed healthcare practitioner or a non-clinical certified PRS supervisor who has worked at least two years providing peer recovery services.

Service Delivery – PRS shall deliver services to Medicaid eligible individuals 18 years of age and older who require recovery-oriented assistance and support to engage in and maintain recovery. Individuals must have a documented substance use disorder or mental health diagnosis.

3. BILLING FOR PBRSS AND ENCOUNTER DATA REQUIREMENTS

Peer Based Recovery Support Services must be billed by a Medicaid-enrolled provider through standard claiming procedures. Providers shall bill for Medicaid members only using the CMS-1500 Professional claim form. All PBRSS shall be recorded in 15-minute units. The PBRSS provider shall submit claims for the following:

- face-to-face (1:1) peer recovery services using the designated code H0038:U2 for mental health services and H0038:U3 for substance use disorder services, The rate for this service is $13.50/15-minute unit.

- Group peer recovery services using the designated code H0038:U2 HQ for mental health services and H0038:U3 HQ for substance us disorder services. The rate for this service is $4.00/15 minute unit for a maximum of 10 participants.

EOHHS and BHDDH will review the data contained in the submissions for the individuals receiving PBRSS to validate that the program standards were provided, and to collect data to review the quality of the service.

The provider must include the Provider NPI, assigned taxonomy 175T00000X (Peer Specialist: Other Service Providers) and a mental health and/or substance us disorder diagnosis for this service**.**

Providers are responsible for verifying the member's eligibility before submitting the bills for payment. The provider shall not bill more than 32 units of PBRSS per day for each member.

Member's will be determined eligible for PBRSS based on the following criteria:

a. Are 18 years of age or older;
b. Eligible for Medicaid or a Medicaid beneficiary;
c. Maintain a mental health and/or substance use disorder diagnosis;
d. Is in need of support to maintain his/her stability in the community; and
e. Are not enrolled in any service in which PBRSS is already delivered.

Process for confirming Medicaid eligibility. Medicaid eligibility will be confirmed using the Healthcare Portal (HCP). To access the HCP, providers must obtain a Trading Partner ID (TP ID). Please visit the HCP page on the EOHHS website for more information on:

- Enrolling as a Trading Partner
- Registering a Trading Partner
- How to use the HCP

Once enrolled, it is the provider's responsibility to ensure recipients are eligible for Medicaid. Providers will need to confirm that recipient's coverage includes Benefit Plan Details that state Categorically or Medically Needy for the dates of service being searched. Peer Based Recovery Support Services are considered out of plan services. If the Medicaid Beneficiary has a managed care plan, services will be billed to Fee for Service Medicaid, not the health plan.

4. LENGTH OF STAY

There is no expectation around the length of time an individual remains engaged with a PRS so long as they continue to meet the medical necessity criteria. Peer Based Recovery Support Services are, however, subject to restrictions of no more than 32 units per day.

5. DOCUMENTATION REQUIREMENTS

Providers shall maintain all records for any follow up auditing upon the request of the State for a period of 10 years as dictated by State or Federal record retention policy, based on the statute of limitations as stated in RIGL § 9-1-13(a) and RIGL § 40-8.2-4. Patient records shall include documentation of services delivered, resources provided, and any follow-up indicated. This is to include but is not limited to:

1. Date, start time/end time of contact with PRS
2. Progress notes, dated and signed
3. Case management notes/referrals dated and signed
4. Reason for completion of services

6. NOTICE PROCESS AND APPEALS

Once it is determined an individual shall receive Peer Based Recovery Support Services, providers must complete a form that ensures that the individual has consented to participate in peer recovery services. This is a voluntary program. If consent is not properly captured and attested to in the member's record, the State reserves the right to recoup any funds paid for the service.

As part of the initial engagement process, members are to be given a written copy of the BHDDH and EOHHS process to file a complaint, appeal a decision, or request a hearing. The process to file a complaint with the state mental health authority (BHDDH), is written in the Rule and Regulations for the Licensing of Behavioral Healthcare Organizations, Section 19, Concern and Complaint Resolution Procedure. The Appeal Process is written under the Executive Office of Health and Human Services, Medicaid Code of Administrative Rules, Section 0110 Complaints and Hearings.

7. PROGRAM INTEGRITY

EOHHS shall engage in periodic audits to review clinical criteria on a sample of members from each provider. The audit may be based on a random sample of members or on a targeted sample of members if there are anomalies in service mix, metrics, staffing, or other programmatic characteristics.